

David M. Golden, et al. vs. County of Suffolk  
Superintendent Gerard Horgan

September 13, 2007

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UNITED STATES DISTRICT COURT  
DISTRICT OF MASSACHUSETTS

C.A. No. 04-10835-MEL

DAVID M. GOLDEN, et al.,

Plaintiffs

vs.

COUNTY OF SUFFOLK,

Defendant

DEPOSITION OF: SUPERINTENDENT GERARD HORGAN

SUFFOLK COUNTY SHERIFF'S DEPARTMENT

Suffolk House of Correction

20 Bradston Street

Boston, MA 02118-2705

September 13, 2007

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GABRIEL & SWEENEY COURT REPORTING

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1 Q. There's nothing in writing on that?

2 A. No.

3 Q. Is an inmate allowed to put additional furniture in  
4 a cell?

5 A. No.

6 Q. As of February 2003, what was the Suffolk County  
7 Sheriff Department knowledge of a safe way for an inmate  
8 to get up to the top bunk in --

9 MS. FABELLA: Just note my objection to the  
10 form of the question. I'm sorry.

11 Q. (By Mr. Tobin) -- in Cell No. 19, Unit 4-3?

12 A. I mean, I can't speak to what the inmates, you know,  
13 what their knowledge is. What I can speak to is what I've  
14 observed. I've seen inmates step on the chair to get up,  
15 step on the window sill to get up, step on the table to  
16 get up. Sometimes just pull themselves up, step on the  
17 bottom bunk and kind of pull themselves up as well. I've  
18 seen inmates do all of that.

19 Q. In February 2003, did the sheriff's department have  
20 knowledge of the safest way to get up onto the upper bunk?

21 A. Safest way? No.

22 Q. As of February 2003, did the sheriff's department  
23 consult with any type of safety consultants to determine  
24 the safest way or a safe way?

1 MS. FABELLA: Again, just note my objection  
2 to the form of the question.

3 You can answer.

4 A. We're audited twice a year by the Department of  
5 Correction, and they come in and give us safety tips every  
6 time they come in. They come in once to do a preliminary  
7 audit and then to do a final audit.

8 And I've been doing those audits for 10 years. And  
9 they've never indicated to us a better way or a worse way  
10 for inmates to get up on the top bunk. It's never been an  
11 issue when they've come in and audited us.

12 Q. (By Mr. Tobin) Have you ever asked them about that  
13 issue?

14 A. We ask them frequently about it. "When you walk  
15 around, can you tell us something -- if you see something,  
16 fresh set of eyes, that would make this place run better  
17 and be more safe, let us know."

18 Specifically about bunk beds, no. But that  
19 general -- and they give us ideas and input on a lot of  
20 matters, but they've never mentioned bunk beds.

21 Q. You mentioned that you've -- so the Suffolk County  
22 Sheriff Department knowledge as to the safe way to get up  
23 to the bed is obtained from observing how the inmates do  
24 it?

1 table was capable of holding?

2 A. I don't.

3 Q. Have you yourself ever stepped up on a table?

4 A. Yes.

5 Q. Can you tell us the dimensions of the table? How  
6 high is it?

7 A. I don't know.

8 Q. As of February 2003, had the Suffolk County  
9 Sheriff's Department ever given any consideration of doing  
10 anything to minimize the chance of an inmate getting  
11 injured while trying to climb up to the top bunk?

12 A. Yes.

13 Q. And what was that?

14 A. There was a discussion about putting a ladder that  
15 was attached to the top bunk and the bottom bunks, Bunk A  
16 and B, to have the inmate climb up on the ladder.

17 Q. And do you remember when that discussion happened  
18 roughly?

19 A. It would have been before I went back to the jail in  
20 January of 2003. I'm not sure of the exact date. It  
21 would have been in the early 2000s.

22 Q. Before January '03?

23 A. Yes.

24 Q. And what were the reasons for those discussions?

1 A. We have an inmate grievance coordinator. And part  
2 of that person's role is to identify potential issues that  
3 may come up from time to time. And I think an issue came  
4 up where someone fell off of a bunk and filed a grievance.  
5 And he brought that up through the chain of command. He  
6 brought that up through the command staff.

7 And there was a conversation that the superintendent  
8 at that time held with a number of other command staff  
9 members regarding the pros and cons, the merits or the  
10 downsides, of having ladders in the cells.

11 Q. And what was ultimate -- what were those pros and  
12 cons?

13 A. Basically that if you have a ladder in the cell, if  
14 someone is suicidal, that's a potential for them to hang  
15 themselves from the ladder. That was a definite con.

16 Kind of the pros and cons were that someone climbing  
17 up on a ladder could fall as well. So we didn't view that  
18 to be a failsafe option.

19 I think what happened was there was a cost-benefit  
20 analysis or a risk analysis done, and a determination was  
21 made that the ladders were not a cure-all and would not  
22 solve the problem -- not completely solve the problem or  
23 even solve the problem a little bit and potentially could  
24 cause another one with suicide risk.

1 Q. Were there any written documents generated regarding  
2 that analysis?

3 A. I don't think so. No.

4 Q. It was oral discussion?

5 A. It was a meeting. Yes.

6 Q. Other than that discussion that you told us about,  
7 were there any other considerations given to doing things  
8 to minimize the risk of an inmate being injured climbing  
9 up to the top bunk?

10 A. Again, at the time, I oversaw inmate grievances, and  
11 we do something that's called a climate control analysis.  
12 We look at issues that are coming up. For example, if we  
13 have a lot of issues on inmates losing property and filing  
14 grievances, that's something we react to.

15 Inmates falling out of bunk beds didn't happen that  
16 often, and it wasn't something we viewed as an epidemic by  
17 any stretch. If you were to list the top ten reasons for  
18 grievances, bunk beds were nowhere near the top ten and  
19 very rarely came up.

20 So I think from our perspective, it was an issue  
21 that was not percolating, and it was an issue that was not  
22 something that needed immediate attention because it  
23 really wasn't happening.

24 Q. Was there ever any consideration given to putting



1 before January '03 from an individual who claimed he  
2 somehow got hurt as a result of trying to get up on a bunk  
3 bed --

4 A. Yes.

5 Q. -- is that your memory?

6 A. Yes. I don't know if got hurt, but the issue of  
7 falling. I'm not sure if it resulted in injury, but it  
8 was something that the grievance coordinator thought he  
9 should bring to our attention.

10 Q. Other than that incident, was Suffolk County  
11 Sheriff's Department aware before February 3, 2003 of any  
12 other inmates claiming they were injured while trying to  
13 get up or down from the upper bunk?

14 A. I know, for example, in the calendar year 2002,  
15 there were seven such claims. And again, I think you have  
16 to put it in perspective. You look at the year 2002, our  
17 average daily population was somewhere between 1500 and  
18 1900, depending on the time. We had over 5,000 people  
19 committed to us that year.

20 And I also know out of those seven claims, at least  
21 one or two of them were proven to be false. The inmates  
22 had issues, and the inmates knew that there was a protocol  
23 if they needed a bottom bunk for a medical reason, they  
24 could get it.

1 Q. Before February 2003, was there any policy or  
2 procedure at the Suffolk County Sheriff's Department to  
3 review these records to see what type of injuries were  
4 allegedly happening on the premises?

5 A. Yes.

6 Q. And how would that -- what was the manner that that  
7 would work?

8 A. There is a health service administrator who oversees  
9 all the medical staff, the doctors, the midlevel  
10 practitioners, the nurses, other people, too, but there is  
11 a weekly meeting that is held with issues that occur  
12 during the course of the week, hot topics, if you would.

13 And there is a -- at the time, actually, I was in  
14 that role where I would meet with the HSA every week and  
15 talk about issues that may or may not have come up  
16 medically that we needed to address.

17 Q. Do you recall ever participating in an HSA meeting  
18 where the issue of inmates being injured, going up to or  
19 down from the top bunk was ever discussed?

20 A. No.

21 Q. Is HSA an arm of the sheriff's department or is that  
22 a contractor?

23 A. A contractor at the house of correction. At the  
24 jail, it's different, but I think we're talking about the



1 house, so --

2 Q. Other than those HSA-type meetings, was there any  
3 other procedure in effect at the Suffolk County Sheriff's  
4 Department where the SERT records or the logbook records  
5 would be reviewed by anybody?

6 A. Yes.

7 Q. What was that procedure?

8 A. There is a major of operations and a deputy  
9 superintendent of operations. They would periodically  
10 review logbooks.

11 In addition to that, they would hold staff meetings  
12 with captains, with lieutenants, with sergeants, on a  
13 periodic basis to discuss relevant security issues.  
14 There's also labor relation meetings that existed and  
15 still exist to talk about health and safety issues with  
16 representatives from the various units. So there are a  
17 number of different mechanisms for that.

18 Q. And to your knowledge, did any of those reviews  
19 revolve around the issue of inmates being injured going up  
20 or down from the top bunk?

21 A. No. Again, it happened infrequently, and we didn't  
22 view it to be an issue.

23 MS. FABELLA: And this is before 2003,  
24 you're asking?

1 As of February 3, 2003, did the Suffolk County  
2 Sheriff's Department take any action as a result of  
3 becoming aware of allegations that inmates were injured  
4 while going up or down from the top bunk other than you've  
5 already testified to?

6 MS. FABELLA: Note my objection. It  
7 presupposes that they were aware.

8 And you can answer.

9 A. We didn't at that time, nor at this time do we see  
10 this to be an overwhelming safety issue or potential  
11 injury issue.

12 As I had indicated earlier, there's no -- if there  
13 was an easy fix to this, if there was a black-and-white  
14 answer, we would have done it.

15 One of the gentlemen's whose documentation I just  
16 reviewed -- I think it was the first one. He's what's  
17 known as a Q5. A Q5 is someone who has either attempted  
18 to commit suicide or ideated suicidal tendencies while in  
19 police custody at some time in the past. So in my mind,  
20 from looking at his records, if he had access to a ladder  
21 in his cell, we could be here for another reason, for a  
22 possible inmate death.

23 So in my mind, there was not a security or safety  
24 issue that existed because of the beds. Again, in my mind